DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 1 3 MA

2. STATE: New Jersey

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1902(aa) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ -0-
b. FFY 2005 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 9(c) 7
Attachment 4.19-B, page 9(c) 10
Attachment 4.19-B, page 9(c) 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same
Same
Same
New Jersey (04-13MA)
Approved: 11/19/04
Effective: 07/01/04

10. SUBJECT OF AMENDMENT:
Reporting Requirements for Federally Qualified Health Centers

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Exempt, pursuant to 7.4 of the Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
James M. Davy

14. TITLE:
Commissioner

15. DATE SUBMITTED:
9-28-04

16. RETURN TO:
Div. of Medical Assistance and
Health Services
P.O. Box 712, #26
Trenton, NJ 08625-0712

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: NOV 19 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Sue Kelly

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Non-Institutional Services

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h) **Adjustment For Changes To Scope of Services:** The PPS encounter payment rates may be adjusted for increases or decreases in the scope of services furnished by the clinic during that fiscal year. A change in scope of service is defined as follows: (i) the addition of a new FQHC covered service that is not incorporated in the baseline PPS rate or a deletion of a FQHC covered service that is incorporated in the baseline PPS rate; (ii) a change in scope of service due to amended regulatory requirements or regulations; (iii) a change in scope of service resulting from relocation, remodeling, opening a new clinic or closing an existing clinic site; and/or (iv) a change in scope of service due to applicable technology and medical practice. The process for a change of scope adjustment is as follows:

(1) Providers must follow the Change in Scope of Service Application Requirements, as specified in State regulation. Providers must notify the Division of Medical Assistance and Health Services (DMAHS) in writing at least 60 days prior to the effective date of any changes and explain the reasons for the change.

(2) Providers must submit documentation/schedules which substantiate the changes and the increase/decrease in services and costs (reasonable costs following the tests of reasonableness used in developing the baseline rates) related to these changes. The changes must be significant with substantial increases/decreases in costs, as defined in (3) below, and documentation must include data to support the calculation of an adjustment to the PPS rate.

It is recognized that the change of scope will be time-limited in most cases, due to start-up or phase-in costs associated with the change of scope. As the utilization level phases in, the need for the enhanced rate will diminish. The provider must address this in the change of scope request.

(3) Providers may submit requests for scope of service changes either:
(i) once during a calendar year, by October 1, with an effective date of January 1 of the following year; or

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PPS rates effective January 1, 2001 and July 1, 2001 have been finalized, all subsequent quarterly wraparound reports will be reconciled at 100% of the PPS encounter rate. In the event of an underpayment, DMAHS will reimburse the provider 100% of the amount due. In the event of an overpayment, the provider must reimburse DMAHS 100% of the overpayment within 30 days of the due date of the Managed Care Wraparound Report.

k) **Outstationed Eligibility Workers:** The reimbursement of donation costs related to outstationed eligibility workers will be made on a lump-sum basis once each calendar quarter.

l) **Interest Assessment on Overpayments:** If there is an FQHC obligation after thirty days from the date recovery is initiated, interest will be assessed in accordance with N.J.S.A. §30:4D-17(e), (f) and N.J.S.A. §31:1-1(a).

m) **Cost Reporting, Record Keeping, and Audit Requirements:** All participating FQHCs shall maintain an accounting system, which identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation to support all data.

(1) Participating FQHCs shall submit the following on an annual basis no later than five months after the close of each facility's fiscal year:

a. FQHC Annual Cost Reporting Requirements, as specified in State regulation;
b. Worksheet 2 of the New FQHC Medicaid Cost Reports for First and Second Years of Operation, as specified in State regulation; and
c. Audited Financial Statement.

(2) New FQHCs must file the New FQHC Medicaid Cost Reports for First and Second Years of Operation, as specified in State regulation. The FQHC's first year as a Medicaid provider may represent less than a full year of operation, however, this period is counted as a full year for cost report purposes. Therefore, a cost report is due to the Division for this period, ending on December 1 of the initial year of operation.

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(3) All payments (including supplemental payments under managed care) for services will be suspended until an acceptable cost report is received. One 30-day maximum extension will be granted upon written request only when a provider's operations are significantly adversely affected due to extraordinary circumstances beyond the control of the provider, as provided in Medicare guidelines.

(4) Each provider shall keep financial, statistical and medical records of the cost reporting year for at least six years after submitting the cost report to the DMAHS, or as long as an outstanding appeal exists, whichever is longer, and shall also make such records available upon request to authorized State or Federal representatives.

(5) DMAHS or its fiscal agent may periodically conduct either on-site or desk audits of cost reports, including financial, statistical, and medical records.

(6) The providers must submit other information (statistics, cost and financial data) when deemed necessary by the Department.

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